		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0001628

Facility Name: Monroe County Nursing Home

Address: 500 Illinois (Number) Waterloo (City) 62298 (Zip Code)

County: Monroe

Telephone Number: (618) 939-3488 **Fax #** (618) 939-5030

IDPA ID Number: 376006468001

Date of Initial License for Current Owners: 11/14/1950

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael G. Kaplan **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/2000 to 11/30/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	142	Skilled (SNF)	142	51,830	1
2		Skilled Pediatric (SNF/PED)			2
3	69	Intermediate (ICF)	69	25,185	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	211	TOTALS	211	77,015	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,331	1,022	2,771	5,124	8
9	SNF/PED					9
10	ICF	28,761	19,571		48,332	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,092	20,593	2,771	53,456	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.41%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Adult Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/1952

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 2,771

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/2001 Fiscal Year: 11/30/2001

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 **Report Period Beginning:** 12/01/2000 **Ending:** 11/30/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7**	8	9	10	
	A. General Services											
1	Dietary	302,793	17,322	10,421	330,536		330,536		330,536			1
2	Food Purchase		182,939		182,939		182,939		182,939			2
3	Housekeeping	127,881	24,074		151,955		151,955		151,955			3
4	Laundry	139,073	31,262		170,335		170,335		170,335			4
5	Heat and Other Utilities			313,948	313,948		313,948		313,948			5
6	Maintenance	104,709	5,791	77,368	187,868		187,868		187,868			6
7	Other (specify):*											7
8	**TOTAL General Services**	674,456	261,388	401,737	1,337,581		1,337,581		1,337,581			8
	B. Health Care and Programs											
9	Medical Director			10,500	10,500		10,500		10,500			9
10	Nursing and Medical Records	2,528,009	59,569	2,159	2,589,737		2,589,737		2,589,737			10
10a	Therapy		11,105	156,046	167,151		167,151		167,151			10a
11	Activities	120,670	15,775	1,953	138,398		138,398		138,398			11
12	Social Services	62,565		1,840	64,405		64,405		64,405			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,711,244	86,449	172,498	2,970,191		2,970,191		2,970,191			16
	C. General Administration											
17	Administrative	51,064		78,009	129,073		129,073		129,073			17
18	Directors Fees											18
19	Professional Services			47,302	47,302		47,302		47,302			19
20	Dues, Fees, Subscriptions & Promotions			16,525	16,525		16,525	(125)	16,400			20
21	Clerical & General Office Expenses	209,993	12,430	18,177	240,600		240,600	(3,904)	236,696			21
22	Employee Benefits & Payroll Taxes			807,878	807,878		807,878		807,878			22
23	Inservice Training & Education			2,945	2,945		2,945		2,945			23
24	Travel and Seminar			3,270	3,270		3,270		3,270			24
25	Other Admin. Staff Transportation			2,534	2,534		2,534		2,534			25
26	Insurance-Prop.Liab.Malpractice			69,166	69,166		69,166		69,166			26
27	Other (specify):*											27
28	**TOTAL General Administration**	261,057	12,430	1,045,806	1,319,293		1,319,293	(4,029)	1,315,264			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,646,757	360,267	1,620,041	5,627,065		5,627,065	(4,029)	5,623,036			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Monroe County Nursing Home #0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7**	8	9	10	
	D. Ownership											
30	Depreciation			307,933	307,933		307,933		307,933			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			96,716	96,716		96,716	(10,264)	86,452			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,437	6,437		6,437		6,437			35
36	Other (specify):*											36
37	**TOTAL Ownership**			411,086	411,086		411,086	(10,264)	400,822			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	3,680	59,920	13,649	77,249		77,249		77,249			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,523	115,523		115,523		115,523			42
43	Other (specify):* Nonallowable costs			59,838	59,838		59,838	(59,838)				43
44	**TOTAL Special Cost Centers**	3,680	59,920	189,010	252,610		252,610	(59,838)	192,772			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,650,437	420,187	2,220,137	6,290,761		6,290,761	(74,131)	6,216,630			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(10,264)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(51,259)	43		24
25	Fund Raising, Advertising and Promotional	(6,749)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,904)	21		28
29	Other-Attach Schedule (See attached)	(1,955)	var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (74,131)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (74,131)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Monroe County Nursing Home

ID# 0001628

Report Period Beginning: 12/01/2000

Ending: 11/30/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Monroe County Nursing Home **#** 0001628 **Report Period Beginning:** 12/01/2000 **Ending:** 11/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(3,904)	0	0	0	0	0	0	0	0	0	0	(3,904)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(3,904)	0	0	0	0	0	0	0	0	0	0	(3,904)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,904)	0	0	0	0	0	0	0	0	0	0	(3,904)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Monroe County Nursing Home # 0001628 **Report Period Beginning:** 12/01/2000 **Ending:** 11/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,264)	0	0	0	0	0	0	0	0	0	0	(10,264)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(10,264)	0	0	0	0	0	0	0	0	0	0	(10,264)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(58,008)	0	0	0	0	0	0	0	0	0	0	(58,008)	43
44	**TOTAL Special Cost Centers**	(58,008)	0	0	0	0	0	0	0	0	0	0	(58,008)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(72,176)	0	0	0	0	0	0	0	0	0	0	(72,176)	45

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		N/A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V				N/A				5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5		N/A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 1/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Nat'l Bank-Waterloo		X	Ventilation & Renovation	$5,589.00	03/01/98	$ 510,000	$ 124,729	02/01/06	0.0535	$ 21,098	1
2	First Nat'l Bank-Waterloo		X	Alzheimer Dining Area	$11,083.00	09/15/95	1,329,000	573,310	09/15/02	0.0535	36,152	2
3	First Nat'l Bank-Waterloo		X	Renovation	$4,023.00	04/17/00	355,347	298,745	04/28/10	0.0600	32,053	3
4												4
5												5
	Working Capital											
6	Monroe County	X		Working Capital	demand	N/A	50,000	96,167	demand	0.0500	7,413	6
7												7
8												8
9	TOTAL Facility Related				$20,695.00		$ 2,244,347	$ 1,092,951			$ 96,716	9
	B. Non-Facility Related*											
10								Less: Interest income offset			(10,264)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (10,264)	14
15	TOTALS (line 9+line14)						$ 2,244,347	$ 1,092,951			$ 86,452	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Monroe County Nursing Home COUNTY Monroe

FACILITY IDPH LICENSE NUMBER 0001628

CONTACT PERSON REGARDING THIS REPORT Joy Hoffman

TELEPHONE (618) 939-3488 FAX #: (618) 939-5030

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.	Not-for-profit facility: No real estate taxes paid		$ N/A	$ N/A
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,250 B. General Construction Type: Exterior Brick Frame Brick & Concrete Number of Stories Two

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care	240,075	1949	$ N/A	1
2					2
3	TOTALS	240,075		$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	211		1952	1952	$ 362,776	$	40	$	$	$ 362,776	4
5			1954	1954	155,296		40			155,296	5
6			1959	1959	464,584		40			464,584	6
7			1972	1972	1,262,811	31,570	40	31,570		936,582	7
8											8
	Improvement Type**										
9	Various Improvements			1979	223,119	5,578	40	5,578		126,434	9
10	Various Improvements			1980	12,110	303	40	303		6,563	10
11	Various Improvements			1981	19,476	487	40	487		10,063	11
12	Various Improvements			1982	37,408	935	5-40	935		18,390	12
13	Various Improvements			1983	136,600	3,415	40	3,415		63,747	13
14	Various Improvements			1984	242,178	12,109	5-20	12,109		211,906	14
15	Various Improvements			1985	25,405	1,270	5-20	1,270		20,916	15
16	Various Improvements			1987	66,614	1,318	8-20	1,318		59,330	16
17	Various Improvements			1988	6,602		10			6,602	17
18	Various Improvements			1989	32,306	2,153	15	2,153		26,914	18
19	Various Improvements			1990	96,200	4,065	5-20	4,065		46,749	19
20	Various Improvements			1991	13,393	327	5-20	327		12,671	20
21	Kitchen/Dining Room Improvements			1991	62,884	3,144	20	3,144		31,440	21
22	Elevator			1992	103,298	5,165	5-20	5,165		49,068	22
23	New Duct Work			1992	4,000	200	5-20	200		1,900	23
24	Flooring			1992	4,200	210	5-20	210		1,995	24
25	Entry Way Improvements			1992	16,415	821	20	821		7,389	25
26	Other Various Improvements			1992	7,135	357	20	357		3,392	26
27	Entrance Addition			1993	521,219	26,453	20	26,453		208,488	27
28	Elevator Installation			1993	44,480	2,224	20	2,224		17,792	28
29	East Hallway Renovation			1994	41,176	2,059	20	2,059		15,443	29
30	Second Floor Sprinkler			1994	29,312	1,466	20	1,466		10,995	30
31	Boiler Room Repair			1994	2,732	182	15	182		1,365	31
32	Air-Handler Repair			1994	2,231	149	15	149		1,118	32
33	Electrical Work			1994	7,000	350	20	350		2,625	33
34	Various Improvements			1995	10,289	686	15	686		4,582	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various Improvements	1995	$ 20,355	$ 1,018	20	$ 1,018	$	$ 6,776	37
38	Alzheimers Dining/Activity Area	1996	1,208,699	60,435	20	60,435		332,393	38
39	Heat & A/C Project	1996	83,800	4,190	20	4,190		23,045	39
40	Architect Fees	1996	70,506	3,525	20	3,525		19,388	40
41	Additional Costs	1996	12,811	641	20	641		3,526	41
42	Garden Project	1996	14,350	957	15	957		5,264	42
43	Fire Panel Upgrade	1997	7,503	1,072	12	1,072		4,824	43
44	Heaters	1997	8,341	1,191	12	1,191		5,360	44
45	Insulated Glass	1997	6,580	940	12	940		4,230	45
46	Cabinet Drywall	1997	4,212	602	12	602		2,709	46
47	Sidewalk	1997	700	47	15	47		209	47
48	Generator	1997	41,462	5,923	12	5,923		26,684	48
49	Painting	1998	24,644	1,232	20	1,232		4,825	49
50	Elevator Motor/Feeders	1998	7,991	399	20	399		1,463	50
51	Flooring - East Wing	1998	1,328	66	20	66		220	51
52	Closet Doors	1998	2,342	117	20	117		361	52
53	Sinks & Faucets	1998	422	21	20	21		81	53
54	Cabinets - 2E & 3E	1998	1,191	60	20	60		230	54
55	Counter Tops	1998	883	44	20	44		165	55
56	Architect Fees	1998	51,048	2,552	20	2,552		8,932	56
57	East end closets	1998	3,465	173	20	173		606	57
58	IDPH bid review	1998	2,400	120	20	120		420	58
59	Drywall	1998	19,500	975	20	975		3,413	59
60	HVAC	1998	342	17	20	17		60	60
61	Fire sprinklers	1998	30,294	1,515	20	1,515		5,302	61
62	Water heater	1998	724	36	20	36		125	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,639,142	$ 194,864		$ 194,864	$	$ 3,347,726	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,639,142	$ 194,864		$ 194,864	$	$ 3,347,726	1
2	Painting	1998	746	37	20	37		130	2
3	Plastering	1998	11,709	585	20	585		2,047	3
4	Demolition, site work, asphalt, excavation	1998	33,920	1,696	20	1,696		5,936	4
5	Concrete, precast, flatwork, steel, carpentry	1998	74,300	3,715	20	3,715		13,003	5
6	Millwork, doors, roofing, sheetmetal, sealants	1998	18,960	948	20	948		3,318	6
7	Glass/glazing, drywall, painting/wall covering, flooring	1998	104,080	5,204	20	5,204		18,214	7
8	Toilet, fire protection, plumbing, HVAC, electrical	1998	271,827	13,593	20	13,593		47,575	8
9	Contingency, general, bonds, change orders, contractor's fee	1998	121,885	6,094	20	6,094		21,329	9
10	Painting	1999	31,380	1,177	20	1,177		4,315	10
11									11
12	Air system - east wing	2000	337,536	16,877	20	16,877		25,316	12
13	Painting	2000	4,913	246	20	246		267	13
14	Canopy	2000	6,160	308	20	308		462	14
15									15
16	Fire alarm	2001	4,797	20	20	20		20	16
17	Architectural inspection	2001	6,119	102	20	102		102	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,667,474	$ 245,466		$ 245,466	$	$ 3,489,760	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 807,712	$ 57,690	$ 57,690	$	5-20	$ 699,432	71
72	Current Year Purchases	20,373	486	486		7	486	72
73	Fully Depreciated Assets	71,977					71,977	73
74								74
75	TOTALS	$ 900,062	$ 58,176	$ 58,176	$		$ 771,895	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	1996 Ford Bus	1996	$ 42,892	$ 4,291	$ 4,291	$	5	$ 42,892	76
77										77
78										78
79										79
80	TOTALS			$ 42,892	$ 4,291	$ 4,291	$		$ 42,892	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,610,428	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 307,933	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 307,933	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,304,547	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Architectural drawing	$ 320	92
93			93
94			94
95		$ 320	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 6,437 Description: Dishwasher - 1,533; Copiers - 4,904
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	1,913	$ 28,701	$	1,913	$ 28,701	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		535	8,028		535	8,028	2
3	Licensed Recreational Therapist	10A(3)	hrs							3
4	Licensed Physical Therapist		hrs		6,948	86,853		6,948	86,853	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				59,910		59,910	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39(1), (2), (3)	244 hrs	3,680	96	843	10	#VALUE!	4,533	12
13	Other (specify): See Attached Sch.	10A(2), 39(3)			4,473	30,696	11,105	4,473	41,801	13
14	TOTAL			$ 3,680	13,965	$ 155,121	$ 71,025	#VALUE!	$ 229,826	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 184,231	$ 184,231	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	832,229	832,229	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	165,655	165,655	5
6	Prepaid Insurance	13,358	13,358	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	1,334	1,334	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,196,807	$ 1,196,807	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	24,835	24,835	12
13	Land			13
14	Buildings, at Historical Cost	6,667,474	6,667,474	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	942,954	942,954	16
17	Accumulated Depreciation (book methods)	(4,304,547)	(4,304,547)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attached schedule	4,895	4,895	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,335,611	$ 3,335,611	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,532,418	$ 4,532,418	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 171,418	$ 171,418	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	61,623	61,623	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,857	7,857	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	31,428	31,428	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Vacation	144,360	144,360	36
37	Unearned Income	21,141	21,141	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 437,827	$ 437,827	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,092,951	1,092,951	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,092,951	$ 1,092,951	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,530,778	$ 1,530,778	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,001,640	$ 3,001,640	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,532,418	$ 4,532,418	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,589,019	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,589,019	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	412,671	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Minor adjustments**	(50)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 412,621	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,001,640	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,450,068	1
2	Discounts and Allowances for all Levels	(119,059)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,331,009	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	307,866	6
7	Oxygen	21,395	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 329,261	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	825	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	443,170	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,881	19
20	Radiology and X-Ray	2,498	20
21	Other Medical Services	101,353	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 584,727	23
	D. Non-Operating Revenue		
24	Contributions	422,533	24
25	Interest and Other Investment Income***	10,264	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 432,797	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Various Reimbursements	411	28
28a	Equipment Rental	25,227	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 25,638	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,703,432	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,337,581	31
32	Health Care	2,970,191	32
33	General Administration	1,319,293	33
	B. Capital Expense		
34	Ownership	411,086	34
	C. Ancillary Expense		
35	Special Cost Centers	137,087	35
36	Provider Participation Fee	115,523	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,290,761	40
41	**Income before Income Taxes (line 30 minus line 40)****	412,671	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 412,671	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. Facility files as part of County return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,920	2,086	$ 48,417	$ 23.21	1
2	Assistant Director of Nursing	1,990	2,086	42,489	20.37	2
3	Registered Nurses	10,786	11,869	199,413	16.80	3
4	Licensed Practical Nurses	44,377	48,390	712,262	14.72	4
5	Nurse Aides & Orderlies	127,631	138,335	1,418,064	10.25	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,341	3,538	36,341	10.27	9
10	Activity Assistants	9,237	10,463	84,329	8.06	10
11	Social Service Workers	5,320	6,056	62,565	10.33	11
12	Dietician					12
13	Food Service Supervisor	1,877	2,186	30,722	14.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,828	17,950	161,475	9.00	15
16	Dishwashers	14,321	15,351	110,596	7.20	16
17	Maintenance Workers	8,766	9,811	104,709	10.67	17
18	Housekeepers	16,538	18,627	127,881	6.87	18
19	Laundry	16,410	18,673	139,073	7.45	19
20	Administrator	1,587	1,912	51,064	26.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,952	2,112	32,924	15.59	23
24	Clerical	14,013	15,503	177,069	11.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,815	2,087	29,845	14.30	31
32	Other Health Care(specify)	3,955	4,172	81,199	19.46	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	301,664	331,207	$ 3,650,437 *	$ 11.02	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	239	$ 10,421	1(3)	35
36	Medical Director	Monthly	10,500	9(3)	36
37	Medical Records Consultant	40	1,200	10(3)	37
38	Nurse Consultant	3 visits	374	10(3)	38
39	Pharmacist Consultant	Monthly	585	10(3)	39
40	Physical Therapy Consultant	227	10,510	10A(3)	40
41	Occupational Therapy Consultant	84	4,064	10A(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	38	1,841	11(3)	44
45	Social Service Consultant	38	1,840	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	666	$ 41,335		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Baum	Administrator	0%	$ 4,835
Sherry Kruep	Administrator	0%	21,749
Kim Keckritz	Administrator	0%	24,480
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 51,064

B. Administrative - Other

Description	Amount
Management Performance, Inc.	$ 78,009
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 78,009

C. Professional Services

Vendor/Payee	Type	Amount
Ivan L. Schraeder	Legal	$ 11,221
Lashly & Baer	Legal	1,256
Schorb, Brinkman & Co.	Accounting	5,131
Altschuler, Melvoin & Glasser LLP	Accounting	7,829
American Express TBS	Accounting	3,730
ADP	Payroll processing	18,135
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 47,302

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 120,230
Unemployment Compensation Insurance	5,157
FICA Taxes	269,559
Employee Health Insurance	168,030
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	231,880
Pre-employment Testing	3,621
Employee Morale	9,401
TOTAL (agree to Schedule V, line 22, col.8)	$ 807,878

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,196
Health Care Worker Background Check	
(Indicate # of checks performed 97)	948
Life Services Network of Illinois dues	6,017
Chamber of Commerce dues	125
Other dues	1,118
Other subscriptions	121
Less: Public Relations Expense	(125)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,400

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached schedule	3,118
Logding & meals (see attached sch.)	152
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,270

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/2000 Ending: 11/30/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3			N/A										
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 **Report Period Beginning:** 12/01/2000 **Ending:** 11/30/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network of Illinois - 6,017**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,594** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **115,523**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **See attached** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **No. Adequate documentation maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Schorb, Brinkman & Co.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **County audit still in progress.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Monroe County Nursing Home
Facility #: 0001628
12/01/2000 - 11/30/2001

Supplementary Information

Page 5 - Line 29: Other Adjustments	Adjustment	Line Ref.
Nonallowable Chamber of Commerce dues	(125)	20
Nonallowable public relations expense	(1,830)	43
Total	(1,955)	

Page 16 - Line 13: Ancillary Services-Other	Sch V ref	Col 4 Units	Col 5 Cost	Col 6 Cost
Ambulance	39(3)		3,880	
Laboratory	39(3)		4,428	
Xray	39(3)		4,498	
Respiratory Therapy Services	10A(3)	4,473	17,890	
Respiratory Therapy Supplies	10A(2)			11,105
Total		4,473	30,696	11,105

Page 17 - Line 23: Other:	
Construction-In-Progress	320
Asset not yet in service	4,575
Total	4,895

Page 20 - Line 32: Other Health Care	Hours Worked	Hours Paid & Accrued	Wages	Ave. Hrly. Wage
Staff Development	1,933	2,086	39,108	18.75
Medicare (Resident Services) Coordinator	2,022	2,086	42,091	20.18
Total	3,955	4,172	81,199	19.46

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The facility operated an adult day care center. All direct expenses are adjusted out of the cost report.

RECONCILIATION REPORT **Monroe County Nursing** **03:34 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CELL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-74,131	equal to	-74,131	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	86,452	equal to	86,452	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	307,933	equal to	307,933	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	6,437	equal to	6,437	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	3,680	equal to	3,680	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	138,156	equal to	167,151	-28,995	FAILED	Pg16 Z12+Z14..Z16 & Pg 20 X17..X20	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	71,025	equal to	71,025	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,337,581	equal to	1,337,581	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,970,191	equal to	2,970,191	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,319,293	equal to	1,319,293	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	411,086	equal to	411,086	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	137,087	equal to	137,087	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	115,523	equal to	115,523	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,450,490	equal to	2,528,009	-77,519	FAILED	Pg20 K11..K15+K35+K36+K38..K44	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	3,680	-3,680	FAILED	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	120,670	equal to	120,670	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	62,565	equal to	62,565	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	302,793	equal to	302,793	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	104,709	equal to	104,709	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	127,881	equal to	127,881	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	139,073	equal to	139,073	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	51,064	equal to	51,064	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	209,993	equal to	209,993	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,650,437	equal to	3,650,437	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	10,421	< or = to	10,421	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	10,500	< or = to	10,500	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	2,159	< or = to	2,159	0	O.K.	Pg20 X14..X16+X37..X39	B. & C.	i7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,841	< or = to	1,953	-112	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,840	< or = to	1,840	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	51,064	equal to	51,064	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	78,009	equal to	78,009	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	47,302	equal to	47,302	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	807,878	equal to	807,878	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	16,400	equal to	16,400	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	3,270	equal to	3,270	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	115,523	equal to	115,523	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	2,771	equal to	2,771	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	1,092,951	equal to	1,092,951	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	0	equal to	0	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,667,474	equal to	6,667,474	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	942,954	equal to	942,954	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	4,304,547	equal to	4,304,547	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	3,001,640	equal to	3,001,640	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	412,671	equal to	412,671	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S31	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	4,532,418	equal to	4,532,418	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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